



Notice of Independent Review Decision

DATE OF REVIEW: 5/8/08

Amended Date: 5/16/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for epidural injection at C4-5, epidurography and physical therapy, 3 times a week for 4 weeks, lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Texas licensed Neurological Surgeon

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for epidural injection at C4-5, epidurography and physical therapy, 3 times a week for 4 weeks, for the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 4/29/08.

- Fax Cover Sheet dated 4/28/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/28/08.
- Request for a Review by an Independent Review Organization dated 4/3/08.
- Determination Notification Letter dated 3/25/08.
- Reconsideration letter dated 4/25/08.
- Notice to Inc. of Case Assignment dated 4/29/08.
- Fax Cover Sheet dated 4/30/08.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 4/29/08.
- Determination Notification Letter dated 3/25/08.
- Fax Cover Sheet Preauthorization form dated 4/10/08.
- Patient evaluation date not specified.
- Behavioral Evaluation Report dated 3/4/08.
- Follow-up visit dated 2/26/08, 2/7/08, 11/26/07, 7/26/07, 6/6/07.
- Fax with Doctors prescription dated 3/20/08.
- Initial Evaluation dated 2/28/08.
- Prescription dated 2/21/08.
- Preauthorization form dated 3/18/08.
- Health Care Information sheet dated 3/4/08, 2/26/08.
- Request for Reconsideration dated 3/4/08.
- MRI of the Lumbar Spine dated 1/30/07.
- MRI Right Shoulder report dated 6/20/06.
- MRI Cervical Spine report dated 6/20/06.
- Procedure Request form dated 2/26/08.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Not provided for this review.

Diagnosis: Low back strain, status post lumbar fusion (12/19/07) and cervical disc herniation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

This xx year-old female had a date of injury xx/xx/xx. She complained of pain in the low back and numbness of the left posterolateral calf. She also complained of pain in her neck radiating down her right arm and into the hand. A prior note stated the pain was in her left arm. Her neurological examination was normal. An MRI of the cervical spine from 2006 revealed at C4-C5 a disc herniation, causing right-sided neuroforaminal stenosis. The patient is status post laminectomy and

fusion 12/19/2007. Apparently, she had one physical therapy visit postoperatively. An MRI of the lumbar spine dated 01/30/2007, showed slightly worse disc herniation at L5-S1, causing mild left neuroforaminal narrowing. The epidural steroid injection is not medically necessary as stated for the cervical spine. Firstly, there was no objective evidence of a radiculopathy on examination. Secondly, it was unclear whether any other conservative therapy had been performed for the cervical spine, specifically. The physical therapy is not medically necessary, because it was not specified as to whether this is post-operative physical therapy for the lumbar spine or whether it is physical therapy for the cervical spine. The attending physician did not order the physical therapy and the question still remained as to whether this was the initiation of post-fusion therapy for the lumbar spine (which someone else ordered) or whether therapy was requested for the chronic neck pain to follow the cervical ESI. Despite the many pages of medical records sent for review, neither the epidural injection nor physical therapy can be approved. This reviewer upholds the prior denial. The Official Disability Guidelines state, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy):

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing."

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPR – AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES.
- DWC – DIVISION OF WORKERS' COMPENSATION POLICIES OR GUIDELINES.
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN.
- INTERQUAL CRITERIA.
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES.

□ MILLIMAN CARE GUIDELINES.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

- Official Disability Guidelines, Treatment Index, 6th Edition, 2008, Cervical and upper back-ESI.

- Official Disability Guidelines (ODG), Treatment Index, 5th Edition (web), 2008,
Cervical spine ESI; Low Back – Physical Therapy; Cervical Spine – Physical Therapy.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.

□ TEXAS TACADA GUIDELINES.

□ TMF SCREENING CRITERIA MANUAL.

□ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

□ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).